8

POLICY BENEFITS DEPARTMENT
DISABILITY BENEFITS DIVISION

Northwestern Mutual Life
P.O. Box 2918
Milwaukee, Wisconsin 53201-2918

ATTENDING PHYSICIAN'S STATEMENT

Dear Doctor: Your patient is making a claim to us for disability benefits due to an illness or accident. All of the following information is important to us as we evaluate the claim. If you are not currently treating the patient, please answer these questions according to the patient's condition during the time you were treating the patient. Thank you for your prompt completion of this form.

NOTE: Any expense incurred in completing this form is the responsibility of the insured.

PATIENT'S NAME Cynthia A. Taylor

DATE OF BIRTH _____ (MONTH / DAY / YEAR) POLICY NO. 01 020 572

1. DATES OF TREATMENT

	Month	Day	Year
(a) Date of first visit	[illegible]		
(b) Date of last visit	6	3	99
(c) Date of last examination	6	3	99
(d) Frequency of visits	Dr Seidman - Weekly ☐ Monthly ☐ Other ☑ every 3 months		
	Dr Seidman - [illegible]		

2. DIAGNOSIS (include any complications)

Infiltrating Ductular Carcinoma

(a) Subjective symptoms

(b) Objective findings (include x-ray, EKG, lab data and any clinical findings)

3. NATURE OF TREATMENT (include surgery and medications prescribed, if any)

4/28/97 - Modified radical Mastectomy - Pt will now undergo Chemotherapy

4. HISTORY

	MONTH	DAY	YEAR
(a) When did symptoms first appear or accident happen?			

(b) Has the patient ever had the same or a similar condition? ☐ Yes; state when and describe. ☑ No

(c) Is the condition due to injury or sickness arising from patient's employment? ☐ Yes ☑ No ☐ Unknown

(d) Does the patient have other disability coverage to your knowledge? ☐ Yes; with which companies? ☑ No ☐ Unknown

(e) Was the patient referred to you by another physician? ☐ Yes; name and city ☑ No

0742

(f) Did you refer the patient to another physician? ☑ Yes; name & city ☐ No

DR. Seidman - Memorial Sloan-Kettering Medical Oncology

5. PROGRESS

(a) While under your care has the patient ☐ Recovered ☑ Improved ☐ Unchanged ☐ Retrogressed

(b) Has the patient been hospitalized? ☑ Yes From 4/28/97 to 4/30/99 ☐ No

Where? Memorial Sloan-Kettering Cancer Center

EXHIBIT
Borgen 64
5 pages

PENGAD-Bayonne, N. J.

6. PHYSICAL IMPAIRMENT (*as defined in "Federal Dictionary of Occupational Titles")

- ☐ Class 1 – No limitation of functional capacity; capable of heavy work.* No restrictions (0-10%)
- ☐ Class 2 – Medium manual activity.* (15-30%)
- ☐ Class 3 – Slight limitation of functional capacity; capable of light work.* (35-55%)
- ☐ Class 4 – Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity. (60-70%)
- ☒ Class 5 – Severe limitation of functional capacity; incapable of minimal (sedentary*) activity. (75-100%)

7. MENTAL/NERVOUS IMPAIRMENT (if applicable)

(a) Please define "stress" as it applies to this patient.

No trial work

(b) What stress and problems in interpersonal relations has the patient had on the job?

Demands of trial and litigation

- ☐ Class 1 – Patient is able to function under stress and engage in interpersonal relations (no limitations).
- ☐ Class 2 – Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations).
- ☐ Class 3 – Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations).
- ☐ Class 4 – Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations).
- ☐ Class 5 – Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations).

Do you believe the patient is competent to endorse checks and direct the use of the proceeds thereof? ☐ Yes ☐ No

8. EXTENT OF DISABILITY

(a) I understand the duties of the patient's occupation to be: Civil trial attorney

0743

(b) The patient has been continuously totally disabled from his or her occupation. From [illegible] To [illegible]

(c) The patient was partially disabled from his or her occupation.

(d) If the patient is now totally disabled, I would anticipate a return to partial work activity in the patient's usual work in: ☐ 1 month or less ☐ 1 to 3 months ☐ 3 to 6 months ☒ 6 to 12 months ☐ more than 12 months ☐ Never

(e) If the patient is totally disabled for his or her usual work, could the patient return to other work? ☐ Yes ☒ with restrictions ☐ without restrictions When? [illegible] ☐ No

(f) What are the patient's current limitations?

[illegible]

9. REMARKS

Some states require us to inform you that any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information may be subject to criminal and civil penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed. In New York the fine shall be $5,000 and the stated value of the claim for each such violation.

Patrick [illegible] MD 212-[illegible]

NAME OF ATTENDING PHYSICIAN (PRINT) DEGREE (AREA CODE) TELEPHONE

[illegible] St. NY NY 1002[illegible]

STREET ADDRESS CITY OR TOWN STATE OR PROVINCE ZIP CODE

[signature] 6/3/99

SIGNATURE DATE

PLEASE SEND A COPY OF YOUR OFFICE NOTES WITH THIS FORM

POLICY BENEFITS DEPARTMENT
DISABILITY BENEFITS DIVISION

Northwestern Mutual Life
P.O. Box 2918
Milwaukee, Wisconsin 53201

ATTENDING PHYSICIAN'S STATEMENT
(FOR CONTINUING DISABILITY)

To the Insured:
Please give this form to your doctor to be completed and returned to us by 2-10-96.

INSURED	POLICY NUMBER
Cynthia M Kaylor	D1070572

Dear Doctor: The following information is needed from you to help us evaluate your patient's continuing disability. Any expense incurred in completing this form is the responsibility of the insured.

1. PRESENT CONDITION
   (a) Subjective symptoms
   INFECTION - SKIN GRAFT DONOR SITE.

   (b) Objective findings.
   Include results of current x-rays, EKGs or other tests
   HIGH RISK STAGE II BREAST CANCER, (16+ AXILLARY NODES)

2. DIAGNOSIS
   HIGH RISK STAGE II BREAST CANCER
   INFECTION - SKIN GRAFT DONER SITE

3. NATURE OF CURRENT TREATMENT (include surgery and medications prescribed, if any)
   TAMOXIFEN, CEPHALEXIN 500MG 4X DAILY, WARM BATH 3X DAILY

4. TREATMENT
   (a) Date of first visit ..... 4/24/97 (MM / DD / YYYY)
   (b) Date of last visit ..... 2/3/98 (MM / DD / YYYY)
   (c) Date of last examination ..... 2/3/98 (MM / DD / YYYY)
   (d) Frequency of visits..... ☐ Weekly ☐ Monthly ☒ Other 4- 6 months

5. PROGRESS..... ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed

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EXHIBIT
Borgen 16

6. EXTENT OF DISABILITY

(a) I understand the duties of the patient's occupation to be:

	From	To
(b) The patient has been continuously totally disabled from his or her usual occupation	4/[illegible]/97	pres.
(c) The patient was partially disabled from his or her usual occupation		

(d) If the patient is now totally disabled, I would anticipate a return to partial work activity in the patient's usual work in

☑ 1 month or less ☐ 1 to 3 months ☐ 3 to 6 months ☐ 6 to 12 months
☐ more than 12 months ☐ Never

(e) If the patient is totally disabled for his or her usual work, could the patient return to other work?

☐ Yes ☑ with restrictions ☐ without restrictions ☐ No When? 2/9/98

(f) What are the patient's current limitations?

1) Left arm - NO Heavy lifting; 10# max
SEE REMARKS

(g) Does the patient have other disability insurance coverage to your knowledge? ☐ Yes; with whom? ☑ No

7. REHABILITATION

If the patient is now totally disabled, is he or she a suitable candidate for a rehabilitation program to assist the patient in returning to work?

☐ Yes ☐ No If no, please explain.

8. MENTAL CONDITION

Is the patient competent to endorse checks and direct the use of the proceeds? ☑ Yes ☐ No

9. REMARKS

A MAJOR STRESS REDUCTION WILL ENHANCE THE LIKELIHOOD OF GETTING THIS DISEASE INTO LONG TERM REMISSION. THIS MAY MEAN A SABBATICAL FROM THIS WORK

Some states require us to inform you that any person who knowingly files a statement of claim containing any false, or misleading information is subject to criminal and civil penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed. In New York, the fine shall not exceed $5,000 and the stated value of the claim for each such violation.

NAME OF ATTENDING PHYSICIAN (PRINT)	DEGREE	(AREA CODE) TELEPHONE
Dr. Borgen MD	MD	(212) 639-5240

STREET ADDRESS	CITY OR TOWN	STATE OR PROVINCE	ZIP CODE
425 E. 67th St.	NY, NY		10021

SIGNATURE

2/3/98
DATE (MM/DD/YYYY)

PLEASE SEND A COPY OF YOUR REPORT AT THIS TIME

POLICY BENEFITS DEPARTMENT
DISABILITY BENEFITS DIVISION

Northwestern Mutual Life
P.O. Box 2918
Milwaukee, Wisconsin 53201

ATTENDING PHYSICIAN'S STATEMENT
(FOR CONTINUING DISABILITY)

To the Insured:

Please give this form to your doctor to be completed and returned to us by _____

INSURED	POLICY NUMBER
CYNTHIA KAYLOR	D1070572

Dear Doctor: The following information is needed from you to help us evaluate your patient's continuing disability. Any expense incurred in completing this form is the responsibility of the insured.

1. PRESENT CONDITION

(a) Subjective symptoms

(b) Objective findings.
Include results of current x-rays, EKGs or other tests

HIGH RISK STAGE II BREAST CANCER, (1/6+ AXILLARY NODES).

2. DIAGNOSIS

HIGH RISK STAGE II BREAST CANCER

3. NATURE OF CURRENT TREATMENT (Include surgery and medications prescribed, if any)

TAMOXIFEN.

4. TREATMENT

(a) Date of first visit ..... 4/29/97 (MM/DD/YYYY)

(b) Date of last visit ..... 8/14/98 (MM/DD/YYYY)

(c) Date of last examination ..... 8/14/98 (MM/DD/YYYY)

(d) Frequency of visits..... ☐ Weekly ☐ Monthly ☒ Other 1 year

5. PROGRESS..... ☐ Recovered ☐ Improved ☒ Unchanged ☐ Retrogressed

EXHIBIT
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5. EXTENT OF DISABILITY

(a) I understand the duties of the patient's occupation to be:

TRIAL LAWYER

	From	To
(b) The patient has been continuously totally disabled from his or her usual occupation	4/18/97	pres.
(c) The patient was partially disabled from his or her usual occupation		

(d) If the patient is now totally disabled, I would anticipate a return to partial work activity in the patient's usual work in

☐ 1 month or less ☐ 1 to 3 months ☐ 3 to 6 months ☐ 6 to 12 months
☐ more than 12 months ☐ Never

(e) If the patient is totally disabled for his or her usual work, could the patient return to other work?

☐ Yes ☒ with restrictions ☐ without restrictions ☐ No When? 2/9/98

(f) What are the patient's current limitations?

1) Left arm NO HEAVY LIFTING; 10# MAX
SEE REMARKS

(g) Does the patient have other disability insurance coverage to your knowledge? ☐ Yes; with whom? ☒ No

7. REHABILITATION

If the patient is now totally disabled, is he or she a suitable candidate for a rehabilitation program to assist the patient in returning to work?

☐ Yes ☐ No If no, please explain.

8. MENTAL CONDITION

Is the patient competent to endorse checks and direct the use of the proceeds? ☒ Yes ☐ No

9. REMARKS

I CONTINUE TO RECOMMEND MAJOR STRESS REDUCTION - THIS WILL ENHANCE THE LIKELIHOOD OF A LONG TERM REMISSION.

Some states require us to inform you that any person who knowingly files a statement of claim containing any false, or misleading information is subject to criminal and civil penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed. In New York, the fine shall not exceed $5,000 and the stated value of the claim for each such violation.

NAME OF ATTENDING PHYSICIAN (PRINT)	DEGREE	(AREA CODE) TELEPHONE
PAT FOGEN MD	MD	(212) 639-5248

STREET ADDRESS	CITY OR TOWN	STATE OR PROVINCE	ZIP CODE
425 E. 67th St	N.Y. N.Y.		10021

Pat Fogen
SIGNATURE

8/14/98
DATE (MM/DD/YYYY)

PLEASE SEND A COPY OF YOUR RECENT OFFICE NOTES WITH THIS FORM.

DISABILITY INCOME DEPARTMENT
DISABILITY BENEFITS DIVISION

Northwestern Mutual Life
P. O. Box 2918
Milwaukee, Wisconsin 53201-2918

ATTENDING PHYSICIAN'S STATEMENT
(for continuing disability)

Dear Doctor: The information you provide on this form is crucial to the consideration of the patient's claim. The more information you can initially provide will both expedite our decision and may reduce our need to request additional information from you in the future. Attaching copies of all clinical lab data, tests (CAT Scans, MRI's, treadmill, EKG, etc.), hospital discharge summaries and your office or chart notes may answer additional questions.

Any cost associated with completion of this form should be billed to the patient. Please mail this form directly to The Northwestern Mutual Life Insurance Company at the address noted above.

To the Insured: Please give this form to your doctor to be completed and returned to us by **11/7/99**

PATIENT'S NAME	DATE OF BIRTH (MM/DD/YYYY)
Cynthia Diveglia	12/22/50
SOCIAL SECURITY NUMBER	**POLICY NUMBER**
195-42-8199	**D1070572**

1. DIAGNOSIS

(a) Diagnosis(es) (including any complications).
Stage II high risk breast cancer.

(b) If applicable, provide the Global Assessment of Functioning (GAF) scale. Current _____ Highest level past year _____
n/a

(c) Symptoms – (Please quantify if possible, e.g. HA's – daily, 8 on a scale of 1-10)
n/a

(d) Objective findings (please attach copies of recent reports, x-rays, EKGs, lab data and any clinical findings as well as copies of the most current objective data which support the diagnosis(es).)
16+ lymph nodes, mastectomy

(e) Current limitations that impair your patient's ability to return to work. Please be as specific as possible.
Major stress reductions to enhance the likelihood of long term remission of the cancer.

(f) Is any follow-up testing planned in the near future? ☒ No ☐ Yes If yes, please indicate the date and type of testing that will be completed.

(g) Did you refer the patient or have other providers seen the patient? ☒ No ☐ Yes
If yes, name and address.

2. TREATMENT PLAN

(a) Current and planned treatment. Please include specific treatment modalities.
tamoxifen 10mg p.o. b.i.d.; major stress reduction

(b) Is your patient compliant with recommended treatment? ☐ No ☒ Yes
If no, please fully explain.

3. PROGRESS ☐ Recovered ☐ Improved ☒ Unchan... ☐ Retrogressed

4. DATES AND FREQUENCY OF MEDICAL CARE

	Month	Day	Year
(a) Date of most recent treatment/examination	10	27	99
(b) Date of next appointment	10		2000

(c) Frequency of treatment ☐ Weekly ☐ Monthly ☐ Quarterly ☒ Other yearly

5. ACTIVITIES AND RESTRICTIONS

(a) What is your understanding of the activities and duties of your patient's occupation?
trial lawyer

(b) Have you restricted your patient from these work activities/duties? ☐ No ☒ Yes, restricted as of Month 0C Day 04 Year 98
If yes, describe the specific restrictions and rationale for restrictions.
major stress reduction, non litigation and no trial work.

(c) To the best of your knowledge is your patient performing any work activities in any capacity? ☐ No ☒ Yes
If yes, please fully explain.
non-trial/litigation attorney duties

6. PROGNOSIS

(a) How long do you anticipate your patient will continue to have work related restrictions as described in 5(b)?
INDEFINATELY

(b) Could the patient work in another occupation? ☐ No ☑ Yes *If yes, please fully explain.*
NONLITIGATION WORK

(c) Do you believe your patient is motivated to return to his/her usual work on a full-time basis?
☐ No ☑ Yes *If no, please fully explain.*
MOTIVATED TO PARTICIPATE IN WORK FORCE IN CONTROLLED SITUATION. NON LITIGATION

(d) Are you aware of any non-medical factors, such as bankruptcy, loss of professional license, personal choice, etc., which inhibit the patient from wanting to or being able to return to his/her usual work or other full-time work?
☒ No ☐ Yes *If yes, please fully explain.*

7. MENTAL COMPETENCY

Do you believe the patient is competent to endorse checks and direct the use of proceeds thereof?
☐ No ☒ Yes *If no, please fully explain.*

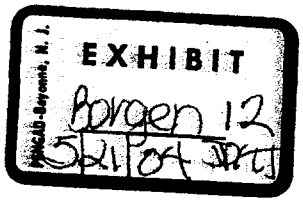
8. REMARKS

Some states require us to inform you that any person who, knowingly and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information may be subject to criminal and civil penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed. In New York, the fine shall not exceed $5,000 and the stated value of the claim for each such violation.

NAME OF LICENSED ATTENDING PHYSICIAN	DEGREE	SPECIALTY	(AREA CODE) TELEPHONE
Patricia Borgen	M D		(212) 639-5245
STREET ADDRESS	**CITY**	**STATE**	**ZIP CODE**
425 E. 67th St.	NY	NY	10021

SIGNATURE

10/27/99
DATE



DISABILITY INCOME DEPARTMENT
DISABILITY BENEFITS DIVISION

Northwestern Mutual Life
P.O. Box 2918
Milwaukee, Wisconsin 53201-2918

ATTENDING PHYSICIAN'S STATEMENT
(FOR CONTINUING DISABILITY)

To the insured:

Please give this form to your doctor to be completed and returned to us by 11-10-99

INSURED	POLICY NUMBER
Cynthia A DiVeglia	D1070572

Dear Doctor: The following information is needed from you to help us evaluate your patient's continuing disability. Any expense incurred in completing this form is the responsibility of the insured.

1. PRESENT CONDITION
   (a) Subjective symptoms
   High Risk Stage II breast cancer,

   (b) Objective findings.
   Include results of current x-rays, EKGs or other tests
   High Risk stage II breast cancer, 16+ lymph nodes, masteectomy

2. DIAGNOSIS
   High Risk Stage II Breast cancer

3. NATURE OF CURRENT TREATMENT (include surgery and medications prescribed, if any)
   tamoxifen 10mg p.o. bid

1999 NOV 12 A 10:44
DI DEPARTMENT
CENTRAL SERVICES

4. TREATMENT
   (a) Date of first visit ..... 4/ 197 (MM/DD/YYYY)
   (b) Date of last visit ..... 10/27/99 (MM/DD/YYYY)
   (c) Date of last examination ..... 10/27/99 (MM/DD/YYYY)
   (d) Frequency of visits ..... ☐ Weekly ☐ Monthly ☑ Other 1 year. prn

5. PROGRESS ..... ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed

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9250 0325

(a) I understand the dut[illegible] the patient's occupation to be: trial lawyer

(b) The patient has been continuously totally disabled from his or her usual occupation ..... From 4-18-97 To 2-9-98

(c) The patient was partially disabled from his or her usual occupation ..... 2-9-98 indefinite

(d) If the patient is now totally disabled, I would anticipate a return to partial work activity in the patient's usual work in

☐ 1 month or less ☐ 1 to 3 months ☐ 3 to 6 months ☐ 6 to 12 months
☐ more than 12 months ☐ Never

(e) If the patient is totally disabled for his or her usual work, could the patient return to other work?

☐ Yes ☑ with restrictions ☐ without restrictions ☐ No When? _____

(f) What are the patient's current limitations?

NON LITIGATION / NON TRIAL WORK -
STRESS REDUCTION -

(g) Does the patient have other disability insurance coverage to your knowledge? ..... ☐ Yes; with whom? ☒ No

7. REHABILITATION

If the patient is now totally disabled, is he or she a suitable candidate for a rehabilitation program to assist the patient in returning to work?

☐ Yes ☐ No If no, please explain.

8. MENTAL CONDITION

Is the patient competent to endorse checks and direct the use of the proceeds? ..... ☒ Yes ☐ No

9. REMARKS

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NAME OF ATTENDING PHYSICIAN (PRINT)	DEGREE	(AREA CODE) TELEPHONE
Patricic Borgen	M.D.	(212) 639-7754
STREET ADDRESS / CITY OR TOWN	STATE OR PROVINCE	ZIP CODE
425 E 67th St. NY NY		10021

SIGNATURE _____ DATE (MM/DD/YYYY) 10/27/99

PLEASE SEND A COPY OF YOUR RECENT OFFICE NOTES WITH THIS FORM.

15-1356 (0798)

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